STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of Affordable Care Act Transitional Policy **Order No. 13-055-M**

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Issued and entered
this 27th day of November 2013
by Annette E. Flood
Director

ORDER REGARDING AFFORDABLE CARE ACT TRANSITIONAL POLICY

On November 14, 2013, President Obama announced a policy that would enable consumers to retain health insurance coverage that had been discontinued due to the Affordable Care Act (ACA) ("transitional policy"). Under the transitional policy, the federal government will not enforce certain ACA market reforms that would otherwise become effective on January 1, 2014. This would allow health insurance issuers to reinstate certain 2013 individual and small business policies that were or would have been discontinued in advance of the 2014 market reforms ("discontinued policies"). Each state has discretion to adopt the transitional policy. Health insurance issuers ("issuers") in states that adopt the transitional policy may, but are not required to, reinstate their discontinued policies. Issuers that choose to reinstate their discontinued policies must notify affected policyholders by using the standard notices supplied by the Center for Consumer Information and Insurance Oversight (CCIIO) on November 21, 2013. Copies of these notices are appended to this Order. Issuers must also inform affected policyholders of any rate increase for the reinstated policies.

Issuers that choose to reinstate their discontinued policies should be aware that those policies must still comply with the following four sections of the ACA and applicable regulations:

- Section 2711 (relating to the prohibition on annual dollar limits on essential health benefits);
- Section 2726 (relating to mental health parity requirements applicable only to individual plans upon renewal on or after July 1, 2014);
- Section 2708 (relating to the prohibition on excessive waiting periods, applicable to small group plans only); and
- Section 2704 (relating to the prohibition on pre-existing conditions).

The Director of the Department of Insurance and Financial Services (DIFS) has decided to adopt the transitional policy and allow issuers to reinstate discontinued policies.

THEREFORE, IT IS ORDERED that issuers may reinstate discontinued policies that meet all of the following criteria:

- The policy was in effect on October 1, 2013[1];
- The policy was discontinued or planned to be discontinued in accordance with federal and state law;
- The policy is renewed[2] once for a policy year that begins between January 1, 2014 and October 1, 2014; and
- The policy is discontinued 12 months after renewal, in accordance with federal and state law.

FURTHER, IT IS ORDERED that, with respect to discontinued policies that are reinstated in accordance with federal guidance and this Order, the following ACA market reforms will not be enforced:

- Section 2701 (relating to fair health insurance premiums);
- Section 2702 (relating to guaranteed availability of coverage);
- Section 2703 (relating to guaranteed renewability of coverage);

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[1] Any modification of policy terms at renewal after October 1, 2013, including term length, will be deemed to create a "new policy," thereby disqualifying the policy from this Order.

[2] The policy must be renewed at its natural expiration date to qualify under this Order. Any policy that is amended to provide for an early renewal date to occur before October 1, 2014 will not qualify under this Order.

- Section 2704 (relating to the prohibition of pre-existing condition exclusions or other discrimination based on health status), with respect to adults, except with respect to group coverage;
- Section 2705 (relating to the prohibition of discrimination against individual participants and beneficiaries based on health status), except with respect to group coverage;
- Section 2706 (relating to non-discrimination in health care);
- Section 2707 (relating to comprehensive health insurance coverage); and
- Section 2709, as codified at 42 U.S.C. § 300gg-8 (relating to coverage for individuals participating in approved clinical trials).

FURTHER, IT IS ORDERED that, with respect to discontinued policies that are reinstated in accordance with federal guidance and this Order, the following sections of state law will not be enforced:

- MCL 500.2213b(4)-(6) and MCL 550.1401e(4)-(6) (relating to guaranteed renewability)[3];
- MCL 500.3428 and MCL 550.1501c (relating to network adequacy standards)[4];
- MCL 500.3472 and MCL 550.1620(2)-(4) (relating to the prohibition of pre-existing condition exclusions and the establishment of open enrollment periods), except with respect to group coverage;
- MCL 500.3474a and MCL 550.1410b (relating to permissible rating factors);
- MCL 500.3612a (relating to permissible rating factors for conversion policies);
- MCL 500.3705(b) (relating to permissible rating factors for small group policies); and
- MCL 500.3712(2) (relating to guaranteed renewability for small group policies).

FURTHER, IT IS ORDERED that issuers that reinstate discontinued policies must, as soon as practicable, send the applicable standard notice supplied by CCIIO to all individuals and/or small businesses that received or would have otherwise received a cancellation or termination notice with respect to the coverage. In addition, issuers must provide a separate notice of any rate increases to affected policyholders as soon as practicable. Both notices must be filed with DIFS as soon as practicable.[5]

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[3] Discontinued policies that are reinstated remain subject to MCL 500.2213b(1)-(3) and MCL 550.1401e(1)-(3).
[4] Discontinued policies that are reinstated remain subject to, if applicable, MCL 500.3530 and MCL 550.1504(1)(a).
[5] The notices of reinstatement and rate increases are subject to review, but not prior approval, by DIFS.

FURTHER, IT IS ORDERED that issuers must comply with the following filing requirements:

- Rates and forms must be filed via SERFF by December 10, 2013, for a January 1, 2014 effective date;
- Rate and form filings must be in compliance with all applicable sections of the Insurance Code of 1956, MCL 500.100 *et seq.*, and PA 350 of 1980, MCL 550.1101 *et seq.*, except as set forth in this Order;
- Form filings must include, under Forms, a copy of the Notice of Reinstatement sent to policyholders;
- Filings must be complete and appropriately designated as filing type "Transitional Rate and/or Form";
- Filings must reference the SERFF tracking number of previously approved form filings; and
- Filings must include an attestation, signed by an officer of the issuer, confirming compliance with this Order.

LASTLY, IT IS ORDERED that issuers that choose to reinstate discontinued policies in accordance with federal guidance and this Order must submit rate filings to DIFS for review and approval before any rate increase can be imposed.

Any violations of this order will result in appropriate administrative action.

Annette E. Flood
Director

Attachment 1

This notice must be used when a prior cancellation notice was sent and the issuer is providing an option to the policyholder to continue the existing coverage:

Dear Policyholder,

We previously notified you that your current policy is being cancelled because it doesn't meet the minimum standards required by the health care law. We are now writing to inform you that, under federal guidance announced in November 2013, you may keep this coverage for the upcoming plan year beginning in 2014.

How Do I Keep My Current Plan?

To keep your current plan, please contact us.

As you think about your options, there are some things to keep in mind. If you choose to renew your current policy, it will NOT provide all of the rights and protections of the health care law. These include one or more of the following new protections of the Public Health Service Act (PHS Act) that were added by the health care law and that take effect for coverage beginning in 2014. As a result, your coverage:

- May not meet standards for fair health insurance premiums, so it can charge more based on factors such as gender or a pre-existing condition, and it doesn't have to comply with rules limiting the ability to charge older people more than younger people (section 2701).
- May not meet standards for guaranteed availability, so it can exclude customers based on factors such as a pre-existing condition (section 2702).
- May not meet standards for guaranteed renewability (section 2703).
- May not meet standards related to pre-existing conditions for adults, so it can exclude coverage for treatment of an adult's pre-existing condition (section 2704).
- May not meet standards related to discrimination based on health status (section 2705).
- May not meet standards for non-discrimination in providers (section 2706).
- May not cover essential health benefits or limit annual out-of-pocket spending, so it might not cover benefits such as prescription drugs and might have unlimited cost-sharing (section 2707).
- May not meet standards for participation in clinical trials, so you might not have coverage for services related to a clinical trial for a serious or life-threatening disease (section 2709).

How Do I Choose A Different Plan?

You have new options and rights for getting quality, affordable health insurance. [You may shop in the Health Insurance Marketplace, where all plans meet certain standards to guarantee health care security and no one who is qualified to purchase coverage through the Marketplace can be turned away or charged more because of a pre-existing condition. The Marketplace allows you to choose a private plan that fits your budget and health care needs. You may also qualify for tax credits or other financial assistance to help you afford health insurance coverage through the Marketplace.][1]

[You can also get new health insurance outside the Marketplace.] Most new plans guarantee certain protections, such as your ability to buy a plan even if you or your employees have a pre-existing condition. [However, financial assistance is not available outside the Marketplace.]

You should review your options as soon as possible, since you have to buy your coverage within a limited time period to preserve your consumer protections.

How Can I Learn More?

To learn more about the Health Insurance Marketplace and protections under the health care law, visit HealthCare.gov or call 1-800-318-2596.

If you have questions, please contact us.

[1] The bracket language does not apply to the U.S. territories that do not have a Marketplace.

Attachment 2

This notice must be used when a prior cancellation notice has not been sent and the issuer is providing an option to the policyholder to continue the existing coverage:

Dear Policyholder,

We are writing to inform you that, under federal guidance announced in November 2013, you may keep your existing coverage for the upcoming plan year beginning in 2014.

How Do I Keep My Current Plan?

To keep your current plan, please contact us.

As you think about your options, there are some things to keep in mind. If you choose to renew your current policy, it will NOT provide all of the rights and protections of the health care law. These include one or more of the following new protections of the Public Health Service Act (PHS Act) that were added by the health care law and that take effect for coverage beginning in 2014. As a result, your coverage:

- May not meet standards for fair health insurance premiums, so it can charge more based on factors such as gender or a pre-existing condition, and it doesn't have to comply with rules limiting the ability to charge older people more than younger people (section 2701).
- May not meet standards for guaranteed availability, so it can exclude customers based on factors such as a pre-existing condition (section 2702).
- May not meet standards for guaranteed renewability (section 2703).
- May not meet standards related to pre-existing conditions for adults, so it can exclude coverage for treatment of an adult's pre-existing condition (section 2704).
- May not meet standards related to discrimination based on health status (section 2705).
- May not meet standards for non-discrimination in providers (section 2706).
- May not cover essential health benefits or limit annual out-of-pocket spending, so it might not cover benefits such as prescription drugs and might have unlimited cost-sharing (section 2707).
- May not meet standards for participation in clinical trials, so you might not have coverage for services related to a clinical trial for a serious or life-threatening disease (section 2709).

How Do I Choose A Different Plan?

You have new options and rights for getting quality, affordable health insurance. [You may shop in the Health Insurance Marketplace, where all plans meet certain standards to guarantee health care security and no one who is qualified to purchase coverage through the Marketplace can be turned away or charged more because of a pre-existing condition. The Marketplace allows you to choose a private plan that fits your budget and health care needs. You may also qualify for tax credits or other financial assistance to help you afford health insurance coverage through the Marketplace.][2]

[You can also get new health insurance outside the Marketplace.] Most new plans guarantee certain protections, such as your ability to buy a plan even if you or your employees have a pre-existing condition. [However, financial assistance is not available outside the Marketplace.]

You should review your options as soon as possible, since you have to buy your coverage within a limited time period to preserve your consumer protections.

How Can I Learn More?

To learn more about the Health Insurance Marketplace and protections under the health care law, visit HealthCare.gov or call 1-800-318-2596.

If you have questions, please contact us.

[2] The bracket language does not apply to the U.S. territories that do not have a Marketplace.

Attachment 3

The following language may be used to satisfy the requirement to notify policyholders (and participants and beneficiaries covered under such coverage) of the discontinuation of their policies. This language should be prominently displayed and placed before language, if any, about auto-enrolling an individual in a specific product:

How Do I Choose A Different Plan?

Even though this plan will no longer be offered, you have new options and rights for getting quality, affordable health insurance. [You may shop in the Health Insurance Marketplace, where all plans meet certain standards to guarantee health care security and no one who is qualified to purchase through the Marketplace can be turned away or charged more because of a pre-existing condition. The Marketplace allows you to choose a private plan that fits your budget and health care needs. You may also qualify for tax credits or other financial assistance to help you afford health insurance coverage.][3]

[You can also get new health insurance outside the Marketplace.] Most new plans guarantee certain protections, such as your ability to buy a plan even if you or your employees have a pre-existing condition. [However, financial assistance is not available outside the marketplace.]

You should review your options as soon as possible, since you have to buy your coverage within a limited time period to preserve your consumer protections. You have 60 days from the time your current plan ends to select a new plan that meets your needs.

How Can I Learn More?

To learn more about the Health Insurance Marketplace and protections under the health care law, visit HealthCare.gov or call 1-800-318-2596.

[3] The bracket language does not apply to the U.S. territories that do not have a Marketplace.